



FHI RESPONDS:

Expanding Prevention, Care and Mitigation Programs during a Decade of Work in Nepal


January 1994–
December 2004




Family Health International

USAID
FROM THE AMERICAN PEOPLE

The decade of prevention, care and mitigation of HIV/AIDS in Nepal has been made possible through financial support from the United States Agency for International Development to His Majesty's Government of Nepal, implemented through the Ministry of Health/ National Center for AIDS and STD Control and Family Health International.

This publication was made possible through financial support provided by United States Agency for International Development (USAID) under the terms of Award No. HRN-A-00-97-00017-00 to Family Health International.

FHI RESPONDS:

Expanding Prevention, Care and Mitigation Programs during a Decade of Work in Nepal

January 1994–
December 2004

Family Health International

USAID
FROM THE AMERICAN PEOPLE

Foreward

Approaching a decade of work on HIV/AIDS in Nepal, it seemed appropriate to reflect back on what has been accomplished and learned and then look forward to future needs. There are numerous accomplishments and lessons learned that have been shared and could be recounted. Yet in the process of capturing the overall picture of FHI's contributions to the national HIV/AIDS program, there were recurring themes of FHI's work that repeatedly surfaced in conversations with staff and partners. FHI chose to highlight each of these themes:

- **Programming both responds to the changing HIV/AIDS epidemic and supports the national HIV/AIDS program.** Over the past 10 years, the epidemic has evolved as have national HIV/AIDS strategies. In support of His Majesty' Government of Nepal, FHI programs and strategies responded to emerging needs of new vulnerable groups and in wider geographic areas. These changes and overall accomplishments are described in the publication, *FHI Responds: Expanding Prevention, Care and Mitigation Programs during a Decade of Work in Nepal*
- **Technical assistance, innovation and leadership strengthen the quality and effectiveness of responses.** FHI in Nepal has both developed innovative interventions and applied international best practices over the years, particularly for HIV/STI prevention. All of FHI's technical and programmatic contributions to the national HIV/AIDS program for prevention, care and mitigation are highlighted in the publication, *FHI Interventions: Initiating Best Practices, Providing Comprehensive Services and Monitoring Impact*
- **Partnerships create synergies, better meet beneficiaries' needs and maximize available resources.** FHI's strength comes from its large network of implementing partners that are able to adapt to local needs and build community-based projects—each of FHI's previous and current implementing agencies is highlighted in the document, *Working in Partnerships: FHI's Implementing Agencies.*
- **Community-based responses best meet the needs of beneficiaries in diverse communities across Nepal.** FHI's combination of research, responsive programming, technical assistance and partners come together in the field where local organizations develop and provide services to those most at risk. The film *The Road Ahead* features FHI's longest running implementation strategy, Safe Highways, and highlights services, needs, beneficiaries and local realities along Nepal's busy transport routes where FHI and its partners implement HIV/AIDS prevention and care projects.

Special thanks for many years of support and partnership with His Majesty' Government of Nepal—especially the National Center for AIDS and STD Control—and the United States Agency for International Development for its continuing commitment to addressing HIV/AIDS in Nepal. Special thanks to our Implementing Partners for their long term commitment and dedication to work in this field, and to the people with whom we work closely in the field and are most affected by this epidemic. FHI looks forward to continuing to support a national comprehensive response to the HIV/AIDS epidemic in Nepal.

Asha Basnyat
Country Director
Family Health International, Nepal

Table of Contents

FHI and its Work in Nepal on HIV/AIDS

Adapting Global Expertise and Experience to Local Needs

FHI around the World: Improving Lives, Knowledge and Understanding Globally

Since 1971, Family Health International (FHI) has become one of the largest and most established non-profit organizations active in international public health. Its mission is to improve lives worldwide through research, education and services in family health to meet the public health needs of some of the world's most vulnerable people. Globally, FHI now aims to provide quality services in two main areas–reproductive health and HIV/AIDS. Through global reach and local action, FHI helps countries and communities to:

- Prevent the spread of HIV and sexually transmitted infections (STIs) and care for those affected by them;
- Improve people's access to quality reproductive health services, especially safe, effective and affordable family planning methods; and
- Improve the health of women and children, especially those who live in resource-constrained settings.

Created as a contraceptive research project, FHI has expanded beyond family planning into many other areas of reproductive health. In 1987, FHI received and then implemented United States Agency for International Development (USAID)'s first large-scale HIV prevention program in developing countries. Since then, FHI has received support from a variety of international donors, governments, private foundations and the private sector to expand HIV/AIDS programs throughout the world including Asia. FHI currently works in more than 70 countries.

WHY FOCUS ON HIV AND AIDS IN NEPAL?

At a time when there were few Nepali with AIDS, HIV was a significant threat to Nepal. As seen in Africa and Asia, an epidemic can develop quickly. As it spreads, HIV/AIDS destroys families, livelihoods, communities, societies and economies.

In limited-resource settings such as Nepal, there are many competing priorities for scarce resources within families, villages and government. Most would be unable to sustain the increased demands and stresses caused by a widespread HIV/AIDS epidemic.

HIV/AIDS programming therefore needs to be prioritized, well resourced, effective and focused to reach those most at risk. The aim is to prevent a generalized epidemic and mitigating its impact.

In Nepal, FHI works with HMG/N and other partners to develop this type of focused HIV/AIDS programs. FHI strengthens quality HIV/AIDS services to reach those most at risk. Programs are designed and monitored to ensure maximum impact and reach.

FHI's Initial Work in Nepal: Preventing the Spread of HIV

In the mid-1980s His Majesty's Government of Nepal (HMG/N) began national HIV/AIDS prevention and control planning. In 1993, a multi-sectoral approach was developed for AIDS and STI control in its *Second Medium Term Plan for AIDS Prevention and Control in Nepal (1993–1997)*. USAID committed its support to provide technical assistance.

In support of this plan's objectives, FHI received funding from USAID to assist HMG/N to reduce the sexual transmission of HIV. Early FHI programs focused on better understanding the epidemic in Nepal and scaling up lessons learned from small-scale prevention projects into a larger, more comprehensive program.

HMG/N and FHI staff jointly conducted initial field visits, assessments and program design. Activities began in 1994 working with seven partners. FHI first focused on reducing high risk sexual behaviors that can spread HIV. FHI worked on the major highways along Nepal's southern border with India to reach female sex workers (FSWs) and their clients in nine districts. FHI promoted safer sex behaviors and concentrated its efforts on building awareness, promoting condom use, and identifying and treating STIs.

Developing and Expanding a Comprehensive Prevention to Care Response

Since 1993, FHI has implemented four main HIV/AIDS programs: *AIDS Control and Prevention Project (AIDSCAP I) (1993–97)*; *AIDSCAP II (1997–2002)*; the *Nepal Initiative (NI) (2001–02)*; and *Implementing AIDS Prevention and Care (IMPACT) (2003–07)*. Each program responded to the latest epidemiological data and modified or expanded activities to increase the effectiveness and reach of services.

FHI's programs now reach more target groups and locations with a wider range of services than ever before. By 2004, FHI had worked in 32 districts, covering the entire length of the East-West Mahendra highway and all other main transport routes in the country. In addition to FSWs and their clients, FHI has expanded programs to reach migrant workers, men who have sex with men (MSM), injecting drug users (IDUs), and people living with/affected by HIV/AIDS (PLHA).

Responding to the needs of the estimated 60,000 Nepali infected with HIV, FHI's comprehensive response now tracks the epidemic, promotes prevention, reduces HIV/AIDS-related stigma and cares for those already infected.

FHI works on this comprehensive response in partnership with the government, organizations, companies, individuals and donors–in particular USAID. Together, this work has made a positive difference, especially in the lives of the millions of people throughout Nepal reached with information, support and services.

The Changing HIV/AIDS Epidemic

When HIV/AIDS Arrived in Nepal: Strong National Commitment, Low Prevalence and Little Epidemiological Information

With the first HIV/AIDS case recorded in Nepal in 1988, HMG/N responded by launching the first National AIDS Prevention and Control Program. But by the early 1990s, there was still little additional information about the HIV/AIDS epidemic in Nepal. In November 1992, HIV Sentinel Surveillance found very low HIV prevalence at 1% among STI patients and FSWs. Other small studies in 1992 in Kathmandu showed HIV prevalence among FSWs under 1% and among IDUs at 3%[1].

In 1993, HMG/N developed its first plan for AIDS and STI control and what is how known as the National Center for AIDS and STD Control (NCASC). At this time FHI began its work in Nepal on HIV/AIDS with USAID funding.

FHI conducted a rapid assessment in 1994 in five towns along the highways in the area of Nepal bordering India. The assessment found that sex work was occurring on both sides of the India-Nepal border, and both FSWs and their clients were very transient. Most had heard of AIDS (over 80% in both groups),

IN THE BEGINNING: LITTLE KNOWLEDGE ABOUT HIV AND VIRTUALLY NO CONDOM USE

In 1994, FHI conducted a study of HIV/AIDS-related knowledge, attitudes and behaviors among over 160 FSWs and 300 of their clients. Surprisingly, FSWs knew little about HIV/AIDS and were doing little or nothing to protect themselves:

- Almost half of FSWs said that their clients never used condoms, and over half said their last client did not use one.
- A remarkable 70% had never asked a client to use a condoms.
- Eight of 10 FSWs had heard of AIDS, but only five of 10 knew how it was transmitted.
- About half of FSWs reported an STI symptom but only half of those women had sought treatment.
- 93% of FSWs knew at least one place to get condoms, but most had never bought or brought a condom.

Among clients surveyed:

- Over 90% of clients had heard of AIDS, and over half knew condoms prevent its transmission.
- Almost all clients were aware where to get condoms, but five of 10 clients had never used one before.
- Two-thirds had not used a condom the last time they visited a FSW.

[1] *National Estimates of Adult HIV Infections*, National Centre for AIDS and STD Control, HMG/N/FHI, 2003

but many didn't know how to protect themselves. Condom use among both groups was low: only about one-third used a condom the last time they had sex.

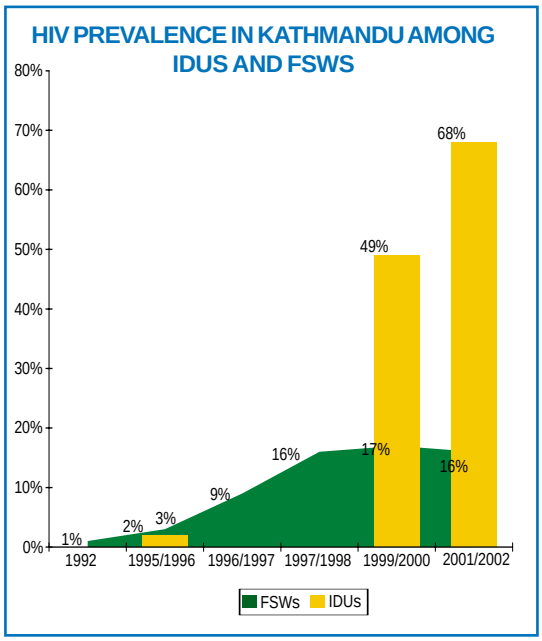
At this time, HMG/N had recorded 32 AIDS cases and over 200 HIV infections. Estimates however were much higher at about 10,000 HIV infected people in Nepal, with a large proportion of these infections acquired in India[2].

A Concentrated Epidemic Develops Quickly

Over the next five years, HIV surveillance increased, and more information about the epidemic became available.

Nepal quickly saw HIV prevalence in small subpopulations in Kathmandu rise above 5%. By 1996, HIV prevalence among FSWs had jumped to 8.7% and then doubled to 17.3% by 1999. IDU HIV prevalence soared to over 50% by 1999.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), these data signaled that Nepal now faced a concentrated epidemic. Further, these rapid changes in just a few years indicated the national surveillance system needed to be strengthened to better detect and track changes. Expanded prevention programs also were needed. Fortunately, other data available showed HIV was still well below 5% in FSWs and their transport worker clients in the *terai plains*, blood donors and pregnant women at antenatal clinics.



Migration on the Map of HIV/AIDS Risk

Along the open borders, millions of people move freely between Nepal and India, including an estimated one million Nepali men who migrate for seasonal employment. Anecdotally, migration to India began to be linked to the growing HIV/AIDS epidemic in Nepal. In Western Nepal people talked of *Mumbai disease* when men came home from India very ill. Stories surfaced from Nepali villages of trafficked girls returning from Mumbai brothels, sick with AIDS. Research among FSWs in 1999 found that those who had worked in Mumbai were twice as likely to have HIV.

This link was soon substantiated in 2001 by a Japanese International Cooperative Agency (JICA)-supported study[3] in Doti district, a hilly, remote district in the Farwestern Nepal. This study found that 10% of Nepali male migrants who returned from Mumbai were HIV positive.

---

2 *AIDSCAP I Final Report*, FHI, 1998

3 Poudel,C et.al. *HIV/STI prevalence and risk behaviors among migrants and non-migrants in Doti district*, 2000

NCASC and FHI quickly conducted studies to see if returning migrants from other high migration districts and to other places in India were equally at risk. In 2002, findings confirmed that migration to India was a risk factor, but the numbers infected with HIV were still quite small:

- In Accham district, HIV prevalence was highest at 8% among those who had worked in Mumbai and other places in India.
- In Kailali district, HIV prevalence was very low among migrants and non-migrants. Only two men were HIV positive, both returning from Mumbai.
- Concerns about migrant men returning to Nepal with HIV/AIDS and infecting their wives were not supported by findings of a 2001 study among women in migrant communities in Kailali district. Only three had HIV–not even 1% of study participants.

The State of Nepal's HIV/AIDS Epidemic

With the findings from Doti district, Nepal's concentrated HIV epidemic was reconfirmed. Using all available epidemiological data, UNAIDS estimated there were 58,000 adults living with HIV/AIDS in Nepal by May 2002. UNAIDS also warned that without effective public health interventions, AIDS could become the leading cause of death for 15-49 year olds by 2010.

In 2003, FHI worked with NCASC to further analyze available data to better understand the current state of the HIV/AIDS epidemic in Nepal. Using the epidemiological estimation methods, national estimates were refined to 60,000 adult HIV infections.

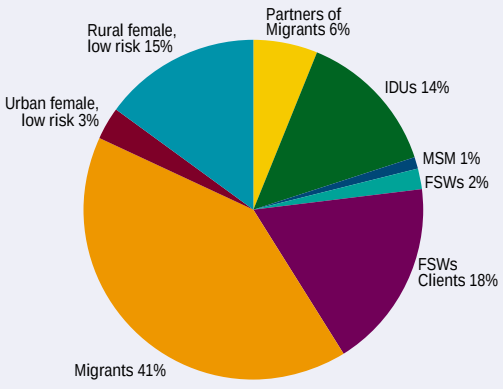
HOW MANY NEPALI HAVE HIV/AIDS?: ESTIMATING THE SCALE OF THE EPIDEMIC IN NEPAL

In 2003, there were dozens of HIV prevalence studies among groups throughout Nepal, but it was difficult to see how all of this information fit together as the national HIV/AIDS epidemic. FHI therefore began an exercise to aggregate all available data into a national estimate of adult HIV cases. The purpose was to draw a more comprehensive picture and better understand which groups and which geographic areas were most affected.

FHI and its research partners collected and analyzed all available biological and behavioral data and most at risk population size estimates to generate a range of prevalence estimates.

Four scenarios were produced, ranging from as low as 28,000 up to 102,000. On average, it was estimated that there were 60,000 adults living with HIV/AIDS in Nepal by the end of 2003.

The largest numbers of cases at almost 25,000 or 41% were among migrant men. While partners of migrant men accounted for 6% of cases, no cases were estimated among female partners of MSM, IDUs or clients of FSWs.



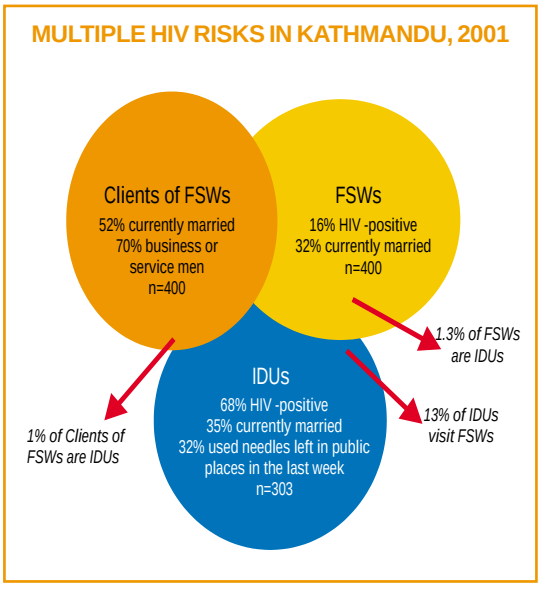
Protecting Those At Risk

Reaching Groups Most at Risk for HIV to Promote Safer, Healthier Behaviors

With an understanding of the dynamics of HIV/AIDS epidemic in Nepal, FHI developed programs aimed at reaching individuals most at risk for HIV and STIs to promote safer behaviors and prevent more infections. Those vulnerable to HIV often have more than one behavior that puts them at risk. For example, FHI research has found that the few FSWs who also inject drugs are more likely to have HIV. Also, while many IDUs share needles, some also report having unprotected sex with FSWs and their regular partners.

Recognizing this overlap of risk behaviors helps improve prevention programs. People vulnerable to HIV because of social, cultural or economic situations often are unaware of risks, ways to modify high risk behaviors or how to access available services.

Over the years FHI has expanded its initial focus on FSWs and their clients to also reach IDUs, MSM, PLHA and Nepali migrant workers who work in India.



Female Sex Workers (FSWs)

FSWs always have been important in FHI's HIV prevention programs. For women who exchange sex for money and/or goods, FHI has designed programs to reduce high risk sexual behaviors. Sexual transmission of HIV is a particular concern because FSWs generally are extremely mobile and have many sexual partners.

In Nepal, sex work is not formally organized or visible. In the larger cities and towns, FSWs often work in restaurants, bars and hotels–and in the capital Kathmandu, also on the street. Along the highways, sex work is

clustered at truck stops and teashops. Despite the differences in locations, FSWs in Nepal have similar profiles and behaviors. Most are between 20-30 years old, literate and currently or previously married. They work three to four days a week and see one or two clients a day. These women are very mobile, changing work places frequently or traveling with clients along the highways to different places.

Almost all FSWs now know about HIV/AIDS and report using condoms with paying clients. Condom use with husbands however is low. Many FSWs drink alcohol frequently, and a few inject drugs.

Despite similarities, risk for STIs and HIV varies among FSWs. For example, FSWs with syphilis or those who have worked in Mumbai are at greater risk for HIV. The most vulnerable FSWs were those working on the streets in Kathmandu: over 17% tested positive for HIV in 2002.

FSWS TALK ABOUT NEGOTIATING CONDOM USE WITH CLIENTS

Though I am highly concerned about contracting STIs and AIDS, but my foolish clients don't like to wear condoms. As I need money, I have no option but to face the risk.—30 years

Army men, students and transport workers carry condoms, but not always. When they don't have condoms I engage in sex without condoms. Sometimes transport workers do not carry condoms and they won't use one. But nothing has happened to me yet.—30 years

I believe that they don't visit other girls. I sometimes suggest that they use condoms, but I can't insist. They don't use condoms willingly themselves.—17 years

Source: *Rapid Qualitative Study of Female Sex Workers in Pokhara,* CREHPA/FHI, 2003; *Focused Ethnographic Study of Risk Behavior and Condom Use among Mobile and Static Female Sex Workers,* CREHPA FHI, 2005

Current estimates place 12,000-16,000 FSWs in FHI's program area: 4,000-5,000 concentrated in Kathmandu and another 8,000-11,000 clustered along the highways.

Clients of FSWs

The most common clients of FSWs are men who are mobile or work away from their homes and families–such as truckers, rickshaw pullers, industrial laborers, migrant laborers, businessmen, campus students, civil servants and security personnel.

Clients—men who offer money, goods or gifts for sex—are young and sexually active. Most are in their mid-20s, but range from teenagers to middle-aged men. They often have free time in the evenings and some disposable income for socializing, drinking and entertainment. The vast majority of clients are literate and know about HIV/AIDS and condoms.

These men visit four to five FSWs a year. While most report bringing and using a condom with the last FSW they visited, about half do not consistently use condoms. FSWs report clients sometimes refuse to use condoms. Five out of six clients do not use condoms with their wives. As the majority of FSW clients are married, the chances of these men passing on HIV or an STI to wives or other partners are high.

Both along the highways and in cities, FSWs usually cite transport workers as a main client group. In both

A CONVERSATION ABOUT CONDOMS WITH A BUS DRIVER ALONG THE EAST-WEST MAHENDRA HIGHWAY

If my friend is interested to go to the sex worker, I give him condoms if he requests. Sometimes I keep condoms and sometimes I run out of stock. But I don't like to keep a condom in my wallet because if my wife knows about it she may think negatively of my character. But I keep condoms in my vehicle.

I use a condom if I have sexual relationship with unfamiliar women/girls. I do not like to use condoms with my wife. Condoms save our life. I use condom to fulfill my sexual desires when I am outside of my home.

Source: *Rapid Situation Assessment of STIs/HIV/AIDS In Highways in Pokhara and Kapilvastu Highways,* Save the Children/US, 2002

1999 and 2003, less than 2% of truckers in the *terai* had HIV and about 5% had untreated syphilis, which was linked to HIV risk.

While there are no studies that have estimated how many men are clients of FSWs, indirect national estimates range from 300,000-700,000.[4]

Injecting Drug Users (IDUs)

Injecting drugs for intoxication, IDUs in Nepal use various types of legal and illegal drugs such as heroin (brown sugar) and buprenorphine (tidigesic). IDUs are at increased risk for HIV and infections such as Hepatitis C by sharing or using unclean needles and syringes.

IDUs are usually young men in their 20s who took other drugs before trying injecting. Over half started injecting after the age of 20, and on average have been an IDU for five years. Most are male and literate.

Female IDUs are smaller in number and quite hidden still in IDU networks. Mainly married and in their early 20s, these women tend to inject at home with their partner or spouse, instead of in public places in larger groups. Almost half started injecting before age 20 and have been using injecting drugs for just over a year.

Most IDUs know about HIV/AIDS and how to prevent it. Yet, even with this knowledge, their injection habits and sexual networks put them at exceedingly high risk for HIV. They inject two to three times a day, often with friends in a group sharing drugs and syringes cleaned with only water or saliva.

PERCEIVED RISK: PRACTICES OF AN IDU IN BIRATNAGAR

I always clean the needle of a syringe with spit before injecting, as spit kills all germs. When I have to use the same old syringe again, sometimes I clean it first with hot water by passing it in the syringe two to three times and then drying it properly with a cloth before pulling the *maal* (drugs). But I clean the syringe only with spit when I am in a hurry. Even my friends do the same.

Source: *Injecting and Sexual Behaviors of Injecting Drug Users in Biratnagar, Nepal,* CREHPA/FHI, 2004

The vast majority of IDUs are sexually active, and often have sex after taking drugs. Among unmarried male IDUs, two-thirds have multiple partners such as FSWs, girlfriends and female IDUs. Condom use by IDUs is infrequent. For example, in Kathmandu only one out of five IDUs used condoms with his regular partner and one out of two with other partners. Some IDUs engage in sex work or exchange sex for drugs.

With national HIV prevalence among IDUs about 40%, the potential to be exposed to HIV in injecting groups and among multiple sexual partners is great. Prevalence among IDUs varies from 22% in Pokhara, 35% in the Eastern *terai* and 68% in Kathmandu[5].

Unfortunately, there are no national IDU data available, but current national estimates range from 16,000-28,000 IDUs in Nepal. Most IDUs are clustered in larger cities and towns.

---

4 HMG/N/FHI, 2003

5 *Behavioral and Sero Prevalence Survey Among Injecting Drug Users in Eastern Nepal,* New Era/FHI, 2004*; Behavioral and Sero Prevalence Survey Among Injecting Drug Users in Pokhara Valley, Nepal, 2003,* New Era/FHI, 2004*; HIV Prevalence And Risk Behaviors Among Male And Female Injecting Drug Users In The Kathmandu Valley,* New Era/FHI, 2002

Men having Sex with Men (MSM)

MSM include gay, bisexual and transgender men. Some MSM exclusively have male partners. Others also have female partners or buy or sell sex with other men. In Nepal, MSM community dynamics and HIV risk behaviors are similar to those well-documented in neighboring South Asian countries.

In Nepal, MSM range in age and education, but many are married and sexually active. MSM often find their partners in public areas that serve as cruising spots. They tend to have many different partners over the course of a year and often have unprotected sex. As in other South Asian countries, the largest numbers of MSM are masculine, nominally heterosexual men. Called *ta*, these men tend not to identify themselves as MSM or gay. *Tas* have sex with more feminine MSM, known as *meti*. Smaller in numbers, *meti* sometimes adopt feminine names, often have many *ta* partners and are less able to negotiate for safer sex. Some *metis* sell sex or are transsexuals.

Before FHI-supported HIV prevention programming for MSM began in 2002, knowledge about HIV/AIDS and perceived risk among MSM was low. With a range of risk behaviors, MSM are vulnerable to HIV and STIs.

OTHER PEOPLE LIKE ME: AN MSM DISCOVERS A COMMUNITY IN KATHMANDU

I came here [Ratna Park in Kathmandu] for the first time five years ago. I did not know that we could meet gays and partners here. I knew about this from the day I came here. I have had sex with one or two of them back in my village. I thought that I was the only one (gay) in this whole world [...] it was only after coming to this park that I came to know there were other people like me.

Source: *Rapid Ethnography of Male to Male Sexuality and Sexual Health in Nepal,* FHI, 2001

As of 2004, there were no data available on the HIV prevalence among MSM in Nepal.

It is estimated there are 5,000-15,000 MSM in Kathmandu and 80,000-170,000 nationwide[6]. This estimate is based on data from other South Asian countries, at 1-3% of the adult male population. No national size estimations have been done to substantiate these estimates in Nepal.

Migrant Workers

For many years, men from rural areas of Nepal have migrated to India for seasonal wage employment to supplement family subsistence farming. This is especially true in Western, Midwestern and Farwestern Nepal.

Nepalese migrant workers range in ages from 16-49 but tend to be in their 20s and 30s. Migrants are mainly married men who travel to India for work, leaving their families behind in Nepal. Through friends or family, they find work in big cities, such as Mumbai. They stay in touch with their villages and homes in Nepal and send money back with friends.

In India, many work as housekeepers, watchmen, cooks, waiters and porters. Most of the Nepali

AWAY FROM HOME: NEPALI MIGRANTS SHARE THEIR REASONS FOR COMING TO MUMBAI

We do not get work in villages. We do not get enough money from farming. If I come here I can feed myself, and save some Rs.1000-1500 (about $ 25-35) every month that could be sent to the family back in the village.—Watchman, 28 years

I have been here for eight or nine years. I used to work in a factory in the beginning. All our relatives from the villages are here. When I walk down the street and see people I feel as if the whole place is my village. I came here because of them.—Watchman, 23 years

My friends used to come wearing nice clothes from Mumbai. I liked that. I felt it must always be like that outside my village. That is why I began to like Mumbai. I came here when I was 15 years old.—Cook, 20 years

Source: *Assessment of Migration and Associated Risk Behavior among Nepali Migrant Men in Mumbai,* FHI, 2003

[6] HMG/N/FHI, 2003

migrant men work and live together. They spend their free time going to movies, meeting friends, drinking, playing cards and visiting FSWs in brothels or at bars.

The majority of Nepali migrant workers are aware of HIV/AIDS and condoms. Condom use however is inconsistent with FSWs, especially when they drink alcohol. When home in Nepal, condom use with their wives is very rare. Data from Accham district suggest that about 8% of male migrants returning from Mumbai are HIV positive, compared to less than 1% for men who have not migrated.[7]

According to HMG/N, estimated numbers of migrant workers range from 600,000 to 1,000,000.[8]

People Living With/Affected by HIV/AIDS (PLHA)

PLHA include a whole range of people from those infected with HIV, those who have AIDS and others are affected by HIV/AIDS—such as the family and friends of an HIV positive person. While national estimates reach up to 60,000 adults living with HIV/AIDS in Nepal, many do not know they are infected. Stigma and discrimination prevent many PLHA from seeking HIV counseling and testing, disclosing their status, practicing safer behaviors and accessing treatment and care services.

From the small PLHA groups in Nepal, the current communities of PLHA are mainly young men who were or currently are IDUs, women who worked as FSWs in India and Nepal, and wives of HIV positive husbands. PLHA are young, between the ages of 18-35. They are both male and female, married and single. PLHA have different needs at all stages of HIV and AIDS. Some struggle with problems such as addiction, alcohol use, general health and hygiene, family support, and financial resources to access drug treatment or medical care. PLHA often feel double stigma from living with HIV/AIDS and because of their behaviors that exposed them to HIV. Women with HIV/AIDS experience more stigma and discrimination than men, even when their partner is also HIV positive.

National estimates place over 40% of adult HIV cases among migrant men and their spouses, yet very little is known about PLHA in migrant communities.

LIVING WITH HIV/AIDS: VOICES OF MALE PLHA IN KATHMANDU

After I became positive I have not been able to work. Now I am too weak to do manual labor and not qualified to do paper work. I am having a hard time sending my children to school...I used to have a small business but later with health problems I have become helpless in all aspects... I have deteriorated very fast in comparison to other people. I feel I cannot even lift a glass of water. — Male PLHA, 37 years

I am too scared of getting sick. I do not want the doctors to tell me that gradually my AIDS is developing. And I do not want the doctors to behave badly with me. I have seen how they treat HIV patients and I do not want to face that.—Male PLHA, 37 years

Source: *Stigma and Discrimination in Nepal: Community Attitudes, and the Forms and Consequences for Persons Living with HIV/AIDS,* FHI, 2003

[7] *FHI/Nepal Five-Year IMPACT Strategy (2003-2007)*, FHI, 2003
[8] HMG/N/FHI, 2003

FHI Strategies

Reducing the Spread of HIV and Providing Care for Those Affected

Expanding Services and Interventions

FHI's contributions to the national response aim to reduce the spread of HIV and prevent a generalized HIV/AIDS epidemic in Nepal. Since 1993, FHI has focused its efforts in Nepal to:

- Change behavior
- Protect health
- Promote prevention and care
- Ensure quality
- Improve care and access to treatment
- Maximize resources
- Strengthen capacity
- Monitor and evaluate programs

FHI IN NEPAL

Mission: FHI works in partnership with HMG/N, NGOs, and local agencies by strengthening capacity to respond effectively to the needs of those affected by HIV/AIDS.

Vision: FHI provides technical leadership to ensure that quality and comprehensive services are available and accessible through local partners to mitigate the impact of the epidemic.

Over the past decade FHI's primary role in Nepal is providing technical assistance to HMG/N and partner organizations implementing a range of activities to curtail the epidemic, promote prevention and provide care. FHI works in partnership with government, non-governmental organisations (NGOs) and associations to provide needed services, gather and respond to evidence, and adapt its approaches to varying communities' needs.

FHI in Nepal provides technical assistance and support for HIV/AIDS prevention, care and mitigation activities. Specifically, FHI offers:

- **Prevention** services including a combination of interpersonal behavior change interventions (BCI), mass media communications, condom social marketing (CSM) and distribution, risk reduction and STI management;

- **Care** for those infected and affected by HIV/AIDS with voluntary counseling and testing (VCT), care and support services (including treatment) and activities to reduce HIV/AIDS-related stigma and discrimination; and
- **Mitigation** of the epidemic through research and surveillance (including epidemiological estimations and research ethics), capacity development in HIV programming, and policy development and support.

RANGE OF FHI INTERVENTIONS: PREVENTION, CARE AND MITIGATION

Implementation Strategies: Reducing Vulnerability to HIV and Improving Care Along Highways, in Cities and in High Migration Areas

FHI's interventions have been implemented and integrated in areas where most at risk groups are concentrated: along highways; in urban areas; and in high migration communities. These strategies evolved over the 10 years of FHI's work in Nepal, beginning first with Safe Highways. Safe Cities and Safe Migration strategies were added in 2002.

Safe Highways

Given the original information on FSWs and their clients, FHI started its work by focusing on areas along the East-West Mahendra Highway. The concept of Safe Highways evolved from this focus.

When Did Safe Highways Begin?

1994

Where and When Did Safe Highways Expand?

- 1994: Started in nine districts
- 1999: Added seven more districts (total 16)
- 2002: Added eight more districts (total 24)
- 2003: Assessed three more districts (total 27)
- 2004: Active programming in 24 districts

Where in Nepal?

- Along main transport routes in Nepal including the Prithivi, Tribhuvan and East-West Mahendra highways and the smaller connector roads to India
- In and around Kathmandu, including the Ring Road and part of the Arniko highway to Bhaktapur
- Through 24 districts

Where Along the Highways?

- From the roadside often just one to two kilometers (just over one mile) into peripheral communities
- At truck parks, bus parks, rickshaw garages, petrol pumps, repair shops and barber shops

- Informal truck stops along the road such as small clusters of tea shops, *bhatti pasals* (liquor shops), food kiosks/carts and restaurants
- At tea estates, factories, river quarries and army or police barracks located along the highways

Who is Reached?

- FSWs and other vulnerable women, such as women in teas shops and small stonebreaking quarries along the road side
- Men who work and travel frequently along the highways and are often clients of FSWs, such as truck drivers, *khalasi* (truck assistants), rickshaw pullers, bus drivers and their assistants, garage workers and uniformed services
- PLHA who live and work along the highways

What are the Main Safe Highways Interventions?

- BCI through peer educators (PEs), communications materials and outreach educators (OREs) to reduce risk behaviors and seek services
- Drop-in centers (DICs) along the highways within:
  - Small community information points at non-traditional venues such as tea shops and repair shops
  - Larger information and service centers such as in truck association offices and NGO offices
- Community-based CSM at traditional and non-traditional outlets[9]
- STI prevention counseling, diagnosis and management at static and mobile clinics located along the highways
- Community awareness and support through special events such as National Condom Day celebrations
- Mass media communications to raise general population awareness about HIV/AIDS and also targeted to reach truckers (such as using large billboards along the highways)
- VCT services integrated into STI service clinics
- Linkages to existing care and support services, as well as mobilization of PLHA support groups
- HIV/AIDS stigma and discrimination reduction activities
- Local advocacy and collaboration through District AIDS Coordination Committees (DACC) participation, cross border collaborative meetings and local stakeholders meetings
- Research and surveillance on populations and risk behaviors along the highways

TAKING STORIES ABOUT LIFE ON THE ROAD, ON THE ROAD: TRUCKERS AND HIV PREVENTION

The 49-minute enter-educate video drama *(Guruji Ra Antare)* captures a series of incidents that befall truck driver Guruji and his helper Antare, during their drive from a southern Nepal border town near India to Kathmandu.

The film cleverly uses the incidents to highlight key messages about condom use and prevention of STIs and HIV. For example, the experienced driver mentors his young friend to "be prepared"—first for unexpected repairs and later for unexpected opportunities to have sex with girls along the route.

FHI supported videovans that traveled along the highways in Central Nepal to show the film. FHI also aired a 19-minute version in four cinema halls free every Saturday morning. The film script was adapted to a street drama and performed by a theatre troupe. An easy to read and entertaining comic book was created too. And to reach truckers on both sides of the border, the film was also dubbed into Hindi.

Safe Cities

As more information on the prevalence of HIV/AIDS among FSWs and IDUs in Kathmandu became available, FHI added Safe Cities as an implementation strategy. Beginning in Kathmandu, FHI reached new target groups such as street-based FSWs, MSM and IDUs with a wide range of services.

[9] FHI supported CSM from 1994 through 2002. Since 2003, FHI coordinates and links to CSM outlets along the highways supported by Population Services International (PSI).

When and Where Did Safe Cities Begin?

2002 in Kathmandu Valley

Where in Nepal?

- In main urban areas that are also connected to main highways
- In three districts of the capital: Kathmandu, Lalitpur and Bhaktapur districts

Where in the Urban Areas?

- Hotels, massage parlors, dance shows and cabin restaurants
- Along the streets and in other public places that are gathering spots or cruising locations for MSM, IDUs and FSWs
- At local transport venues such as the main truck parks, bus parks, rickshaw garages and tempo parks

Who is Reached?

- FSWs including the most vulnerable—street-based FSWs
- Women at risk who work at establishment-based entertainment venues, such as young women who work at restaurants, massage parlors and hotels
- Transport workers, police and day laborers (all often clients of FSWs)
- MSM and male sex workers (MSWs)
- IDUs
- PLHA who live and work in Kathmandu Valley

What are the Main Safe Cities Interventions?

- BCI through PEs, OREs and communications materials to reduce risk behaviors and seek services
- DICs at:
  - Non-traditional venues such as in the bus parks, near clusters of massage parlors, and near the local vegetable market in Kathmandu where many day porters and work
  - More formalized information points in NGO offices
- Community-based CSM at traditional and non-traditional outlets[10]
- STI prevention counseling, diagnosis and management at static and mobile clinics within the valley
- Community awareness and support through special events, such as World AIDS Day and *Gai Jatra* festival celebrations for MSM
- Mass media communications to raise general population awareness about HIV/AIDS and to generate political support among policymakers in the capital

THEY CALL HIM *CONDOM BROTHER*: PRONAP RAJBANSHI HELPS MAKE KATHMANDU "SAFER" FROM HIV/AIDS

Not far from the noisy flow of traffic of a busy road in Kathmandu, a group of men gather. This is one of the capital city's many repair garages, filled with drivers, vehicle owners drivers, *khalasi*, garage workers and mechanics. What draws them together this afternoon is not what you might expect: they have come to watch a film on HIV/AIDS.

FHI has worked with transport workers along the Ring Road of the Kathmandu Valley since 2002—aiming to reduce their vulnerability to HIV and STIs. FHI uses BCI to promote the safer sex messages ABCs: abstinence; being faithful; and condom use. Volunteer PEs like Pronap are an important part of this successful HIV prevention project.

For 42-year old Pronap, it hasn't always been easy to discuss sensitive topics such as sex, HIV/AIDS and condoms. Several years ago, he frequently visited sex workers. It was after watching an FHI film on HIV/AIDS called *Guruji and Anatere* that he became interested in knowing more. Concerned, he went for an STI checkup at an FHI-supported clinic and attended educational sessions.

Soon, he was convinced he "had to do something to make a difference". Pronap became a peer educator and did his job with enthusiasm. He gave out condoms and showed others how to correctly use them. He even gave FSWs condoms, earning him the nickname *Condom Bhinaju* (Condom Brother).

Still, he wanted to do more. On his own, he converted part of his garage into a DIC. From the small shed in Deepti Garage, he distributes brochures, leaflets and condoms to as many young men he can every day. Pronap says he's glad he took that first step to learn about HIV/AIDS and get involved.

[10] FHI supported CSM from 1998-2002 in Kathmandu Valley, with PSI as one of its CSM implementing agencies in 2002. Since 2003, PSI directly supports CSM.

- Risk reduction activities for IDUs, such as the minimum package of services provided under the *Nepal Initiative*
- VCT services at both stand-alone centers and at some integrated STI service clinics
- Linkages to existing care, support and treatment services, as well as mobilization of PLHA support groups
- HIV/AIDS -related stigma and discrimination reduction activities
- Local advocacy and collaboration with public and private hospitals, other HIV/AIDS projects and municipal government officials
- Research and surveillance

Safe Migration

More recently the prevalence of HIV infection among migrants returning from India raised concerns about how easily the virus could spread if thousands of men returned home infected with HIV. In response, FHI has started developing the Safe Migration strategy to support communities with high migrant populations in Western and Farwestern Nepal.

When Did Safe Migration Begin?

2002

How and When Did Safe Migration Expand?

- 2002: two districts (Bajhang and Doti districts)
- 2004: Shifted focus to three different districts with high migration to Mumbai (total three districts)
- 2004: Expanded into Mumbai in coordination with FHI in India

Where in Nepal and India?

- Focused in 10 of 75 Village Development Committees (VDCs), in Accham district, five of 20 VDCs in Kanchanpur district and five of 44 VDCs in Kailali district
- In Mumbai, the Thane and Gore Gaun areas where thousands of Nepali migrant men live

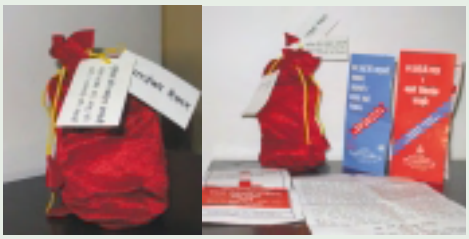
Who is Reached?

- In India, Nepali male migrants
- In Nepal:
  - Migrating men and potential migrants
  - Partners/wives of migrant workers who travel to work in Mumbai
  - PLHA living in these remote communities

REDUCING RISKS: MIGRANT MEN HEAD TO INDIA WITH SAFER SEX SURVIVAL KITS

When migration activities started in two remote Farwestern districts of Nepal, one challenge was how to raise awareness about the HIV/AIDS risks among the young men who migrate to India from almost every family. Focused on economic opportunities, migrants were often unaware of the potential HIV/AIDS risks. The difficulty was how to reach the thousands of men scattered across rural, hillside villages and in large cities of millions in India.

One innovative solution by one of FHI's partners: *kosheli* (gift) kits. These small fabric bags were filled with an informational brochure, a condom with instructions on correct use and a comb.



These bags were distributed at bus parks, the central point for departure. This activity was complemented by orientations on HIV/AIDS and STIs conducted on a regular basis.

Attempts were also made to follow up with these men once in India. A similar bag called *Gaon ko Raiwar* (News from Home) was sent by mail or given to other men going to the same place. Families were encouraged to add personal notes to these packages.

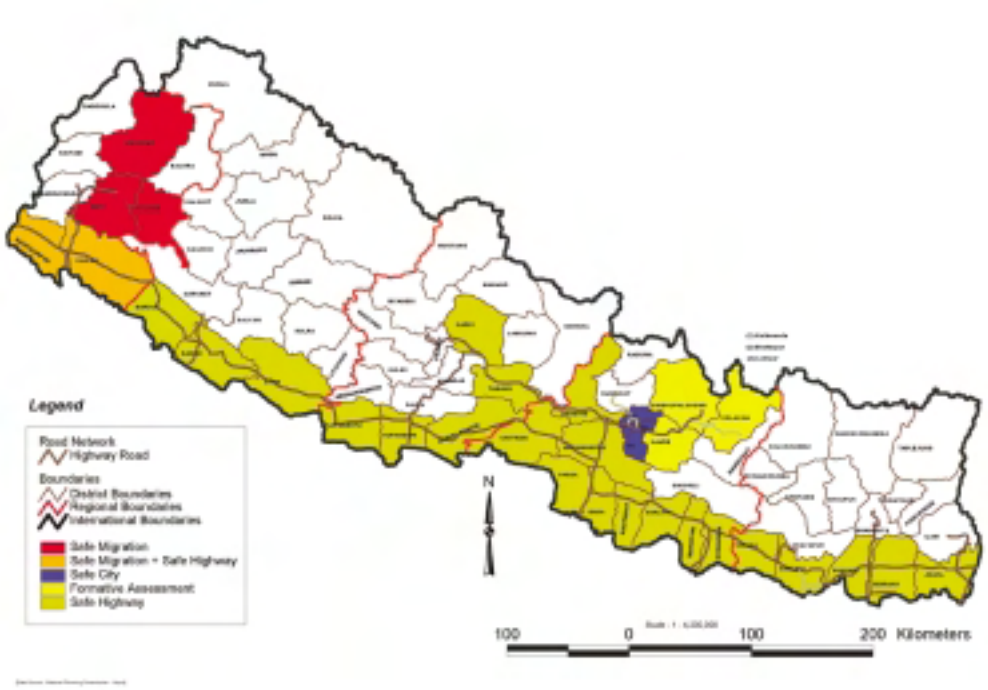
While their husbands were away, wives were offered education about HIV/AIDS through small village communication groups. Facilitated by a PE, thousands of women learned how to protect themselves from HIV/AIDS. While women enthusiastically participated in these groups, they often expressed how difficult it was for them to talk about such sensitive issues and negotiate condom use when their husbands returned home. For this reason, the next phase of FHI migration work shifted to programming in migrant communities in India—in particular Mumbai—to reach Nepali men while away from home and more vulnerable to HIV exposure.

What are the Main Safe Migration Interventions?

- BCI to reduce risk behaviors and seek services:
  - In Mumbai, through PEs, OREs, DICs, radio listeners groups and communications materials
  - In Nepal, current Safe Migration activities are radio listeners groups and communications materials; the initial phase used DICs, migrant wives groups and PEs
- Links to CSM at traditional and non-traditional outlets
- STI demand generation, prevention counseling and referral to existing STI clinics supported by FHI or government health facilities where staff have been trained
- Community awareness and support through group interactions
- Innovative mass media communications using satellite radio and listeners groups called *Desh paradesh* (*My Country and Our Neighbor*) about two cousins traveling to and working in Mumbai,
- Local advocacy and collaboration
- Research and surveillance

By combining Safe Highways, Safe Cities, and Safe Migration strategies, FHI has significantly expanded its reach. This map shows the combined geographic coverage of these three strategies through 2004.

FHI'S IMPLEMENTATION STRATEGIES: SAFE HIGHWAYS, SAFE CITIES AND SAFE MIGRATION



FHI HIV/AIDS Programs: *Expanding over a Decade to Increase Coverage and Services*

FHI has implemented four large-scale HIV/AIDS programs over the past decade for prevention, care and mitigation: AIDSCAP I; AIDSCAP II; NI; and IMPACT. USAID has continuously supported FHI programs and increased its funding for HIV/AIDS since 1993.

AIDSCAP I (1993–1997): Creating a Blueprint for Interventions

AIDSCAP I was the first FHI HIV/AIDS program in Nepal. Funded by USAID, AIDSCAP I started in 1993 and was initially designed as a 3year, $1.2 million project. It applied the lessons learned from previous small-scale prevention projects to develop comprehensive programs to reduce the sexual transmission of HIV, the primary mode of HIV transmission in Nepal.

AIDSCAP I primarily reached FSWs and their clients in nine districts in the Central and Eastern Regions, along the country's primary transport routes mainly in the *terai* area bordering India. FSW clients consisted mostly of transport workers, migrant laborers, businessmen, uniformed services, and campus students. AIDSCAP I's secondary target group was the spouses and partners of these clients.

The AIDSCAP strategic plan was developed in close collaboration with HMG/N and in support of its policies. AIDSCAP I's STI/HIV/AIDS prevention and control strategies aimed to:

- Reduce STIs;
- Increase the use of condoms among populations at risk; and
- Reduce high risk behavior through BCI and outreach education for targeted populations.

This Safe Highways strategic plan first focused on changing the high risk behaviors of these groups. The program started with BCI and phased in other components such as condom distribution and STI treatment. FHI used a multi-pronged approach—including BCI, STI service delivery, mass media communications for condom promotion and surveillance-related research. These

FHI'S INNOVATIVE CROSS BORDER PARTNERSHIPS FOR HIV PREVENTION

Trucks, buses, pedestrians, rickshaws and cattle moving freely across the open border at bustling trade towns between India and Nepal. Several highways converge in Birgunj in southern Nepal to Raxaul, India, making it a main transit point.

In 1994, FHI started HIV/STI prevention outreach to truck drivers and FSWs. Both worked in both India and Nepal and reported high risk behaviors. In 1995, a clinic opened in Raxaul and linked its services with one of FHI's partners.

Funded by USAID, FHI brought Nepali and India NGOs together to strengthen this collaboration. OREs coordinated their activities and crossed the border regularly to work together. Frequent visits, joint training workshops and communication among field staff improved coordination.

Communications materials were translated into Hindi and adapted for India, based on focus group feedback. For example, the Nepal program's logo was changed to remove the Gurkha soldier shield not recognized south of the border.

STI referrals and services were the most important project accomplishment. Reluctant to visit Birgunj's highly visible STI clinic, people were referred with cards printed in Nepalese and Hindi for STI services to the general health clinic across the bridge in India. From 1995–1997, the clinic served an average of 50 clients a day. Almost one of four clients receiving treatment was from Nepal.

This project showed cross border prevention efforts were effective with consistent, culturally appropriate HIV/AIDS prevention messages among mobile populations along the border. It also served as a model and inspired a number of cross border projects in Nepal and along the India-Bangladesh border.

mutually reinforcing prevention activities were integrated and established the foundation for FHI's long term work. FHI worked with 10 implementing agencies that included leading NGOs to implement its activities.

AIDSCAP I demonstrated that prevention interventions designed to reduce high risk behavior, coupled with second generation surveillance, are the cornerstones of HIV/AIDS prevention and mitigation.

AIDSCAP II (1997–2002): Expanding Coverage and Approaches

As AIDSCAP I ended, a new 5-year $5.7 million bilateral cooperative agreement began titled AIDCAP II. Funded by USAID and managed by FHI, AIDSCAP II was a comprehensive prevention and mitigation program that continued and expanded activities to reduce the sexual transmission of HIV in Nepal. AIDSCAP II also expanded AIDSCAP I strategies and aimed to:

- Improve access to quality STI services
- Reduce high risk behavior among target populations
- Improve community-based information advocacy and care systems to effectively respond to the needs of HIV infected people
- Improve HMG/N's capacity to develop policy and surveillance
- Increase private sector participation in HIV/AIDS prevention efforts

REACHING TRUCKERS ON THE ROAD: ILLUMINATING SAFER SEX MESSAGES

Considered a major FSW client group, truckers are mobile and sexually active. Initial research showed these young men knew about HIV/AIDS but rarely used condoms.

In the design of its first campaign, FHI wanted to reach truckers with information about HIV prevention and condom use. At first, 20 billboards were placed along the highways in nine districts, depicting the *Dhaaley Dai* and socially marketed condom logos.

Under AIDSCAP II, FHI significantly expanded the campaign and CSM activities. To expand its efforts to reach truckers, a total of 140 billboards with the campaign logo were placed along the highways. To make the cartoon condom more visible at night, reflective stickers was used to illuminate the condom on the larger billboards.

The campaign used other media to reach truckers and their assistants too. A radio spot of two truckers talking about condoms was aired on Nepal Radio and on regional FM stations in five local languages. Stickers of the campaign logo were given to truckers to adhere in their truck windows. Also, cassette tapes of the most popular Nepali songs were distributed, with campaign jingles and the radio spot between songs.

AIDSCAP II worked through Nepali organizations and with HMG/N. Its coverage was expanded into seven more districts. AIDSCAP II covered the East-West Mahendra Highway from Jhapa to Rupandehi districts, including the north-south connector roads to India. Expansion was designed to complement ongoing outreach and STI control activities being implemented by other organizations, such as in Midwestern and Farwestern Nepal.

AIDSCAP II focused on reducing HIV/STI infection among the primary target groups of FSWs and their clients, and among secondary target including women and men with multiple sex partners, wives with transient husbands and adolescents.

AIDSCAP II expanded the Safe Highway implementation strategy to cover a total of 16 districts. Ongoing interventions were strengthened. For example, the mass media campaign was reinvigorated by adding more

messages and broadcasting in five local languages on FM and regional radio stations. Also, complementary interventions were added, such as community-based CSM.

AIDSCAP II expanded FHIs partners to over 30 organizations. FHI through AIDSCAP II was able to demonstrate that prevention and mitigation activities for FSWs and their clients had a positive impact on reducing high risk sexual behaviors.

Nepal Initiative (2001–2002): Responding Rapidly to Address a Concentrated Epidemic

In 1999 and 2000, research findings showed dramatic increases in HIV prevalence among FSWs and IDUs in Kathmandu, suggesting the HIV/AIDS epidemic had become concentrated. In response, a consortium of international donors—including Department for International Development (DFID), USAID, Australian Agency for International Development (AusAid), UNAIDS and the United Nations Development Programme (UNDP)—developed and funded the Nepal Initiative (NI) to address the needs of specific high risk groups through phased risk reduction programs. FHI was selected as executing agency and worked in close collaboration with HMG/N, groups at risk and NGOs to develop the strategy. NI began FHI's Safe Cities activities.

NI was expected to bridge the time needed to develop a broader, expanded response to address the urgent risk reduction needs of FSWs, FSW clients and IDUs in the Kathmandu Valley and other targeted areas. NI objectives included:

- Create the necessary enabling environment among policy makers, local authorities and communities for concerted action in HIV risk reduction;
- Increase behavior change among individuals at high risk for HIV and STIs, including IDUs, FSWs and their clients;
- Enhance capacity of HIV/STI surveillance systems and their use in key decision making;
- Support and facilitate the design of a costed, long-term strategy for HIV risk reduction among FSWs, clients and IDUs; and
- Develop and implement a monitoring and evaluation system to inform the national response and to monitor and evaluate the project.

NI implemented activities such as advocacy, research, prevention services for IDUs and FSWs, capacity building, strategic planning, and monitoring and evaluation. Implemented simultaneously with AIDCAP II but in different geographic areas, NI offered BCI, STI treatment services and CSM. Unique to this program and to Nepal, FHI introduced a minimum package for risk reduction among IDUs. Advocacy and policy activities were conducted, such as national substitution therapy guidelines development and the *Let's Start Talking About AIDS Today* mass media campaign.

THE NEPAL INITIATIVE TAKES TO THE STREETS TO REACH THOSE MOST VULNERABLE TO HIV: KATHMANDU'S STREET-BASED SEX WORKERS

For many years, a local clinic in Kathmandu offered free STI and VCT services to FSWs. From their experience and research, it was clear that the sex workers who worked on the streets of Kathmandu were those more likely to have these infections. With over 17% of these street-based FSWs positive for HIV, FHI under the Nepal Initiative began active HIV prevention programming to reach these most vulnerable women.

Often poor, less educated and marginalized, they work and sometimes live on the street. Most do not have a safe place to gather, bathe, care for their children or sleep. Access to health care, information and counseling is limited if at all.

In response, an HIV prevention project supported by FHI started in 2001, mobilizing OREs and PEs. Uniquely designed to meet their needs, a Well Being Center was set up in a convenient downtown location to provide daytime shelter, running water and a comfortable place to gather—away from the hassles from potential clients or police. Referrals to STI and other services were available, along with free condoms and communications materials.

When the Nepal Initiative ended in 2002, FHI revised its strategy to reach these FSWs and continued outreach education prevention services.

While NI also worked with over 20 NGO partners, a main component of this project was to work with and support the NCASC and local government bodies to implement activities. Collaboration and coordination were essential to the implementation and success of NI.

IMPACT (2002–2007): Providing a Continuum of Prevention to Care Services

Building previous USAID-supported programs, FHI is currently managing a comprehensive response through the IMPACT Project. IMPACT builds the capacity of Nepali organizations to conduct HIV prevention and care activities and mitigate the impact of the HIV/AIDS epidemic in Nepal.

As with AIDSCAP I and II, IMPACT reaches FSWs and their clients. IDUs, MSM and male migrant workers also are included as target groups. IMPACT assists USAID and NCASC in implementing their respective strategies, monitoring and responding to the HIV/AIDS epidemic, and scaling up prevention to care services for those most at risk. FHI has expanded its work with about 30 implementing partners, aiming to:

- Increase national capacity to manage an effective response to the HIV epidemic;
- Improve the prevention of HIV and other STIs; and
- Implement appropriate care and support strategies to mitigate the impact of the HIV epidemic.

IMPACT works in 29 of Nepal's 75 districts to implement the Safe Highways, Safe Cities and Safe Migration strategies. In all of these implementation strategies, prevention and care services will be strengthened to better reach those at risk and in need. Under IMPACT, FHI provides a range of care, support and treatment services and technical assistance.

INCREASING ACCESS TO VCT: STRENGTHENING AND EXPANDING NATIONAL VCT SERVICES

With estimates of almost 58,000 HIV positive adults in 2002, VCT services needed to be available and accessible. But few centers and hospitals in Nepal offered VCT, and none followed the same counseling or test- ing protocols.

With the beginning of the USAID-supported IMPACT program, FHI prioritized VCT service quality and expansion. In 2002, FHI helped NCASC develop national Guidelines for Voluntary HIV/AIDS Counseling and Testing. These guidelines were finalized in 2003 in English and in Nepali.

To help train counselors and lab staff to deliver VCT services to this new standard, in 2002 and 2003 FHI helped NCASC develop national training curricula for lay counselors, lab staff and VCT counselors. FHI also began developing job aids such as a counselor's flipchart.

Having helped produce quality standards and trained personnel, FHI then worked in partnership with local organizations to set up VCT services. By the end of 2004 there were 15 VCT sites in 10 districts. This is the largest number of VCT centers supported by an international NGO in Nepal.

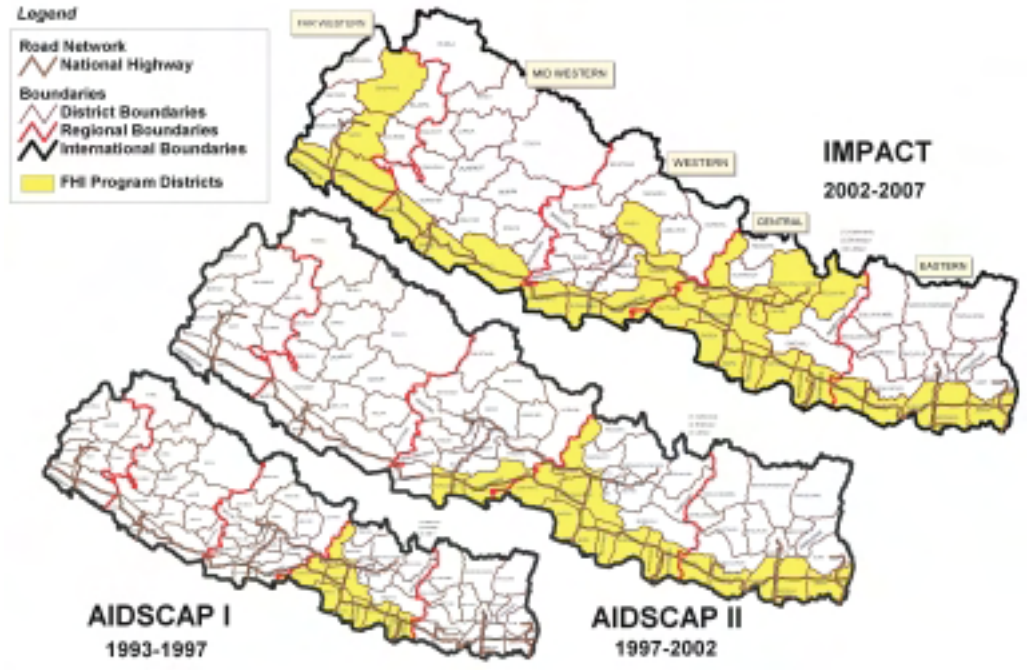
And in addition to increasing access and ensuring quality, FHI also focused on increasing demand for services using peer education and communications materials to raise awareness about VCT services, especially among most at risk groups.

FHI's Expansion of HIV/AIDS Prevention, Care and Mitigation Work

Years Program	1993–1997 AIDSCAP I	1997–2002 AIDSCAP II	2001–2002 Nepal Initiative	2002–2007 IMPACT
Districts	9	16	12	32
Target Groups	• FSWs and their clients	• FSWs andtheir clients	• FSWs andtheir clients	• FSWs andtheir clients
			• IDUs	• IDUs
			• MSM	• MSM
				• Migrant workers and their partners
				• PLHA
Implementation Strategies	• Highways	• Highways	• Highways	• Highways
			• Cities	• Cities
				• Migration
Components and Interventions:				
Prevention	BCI, STI, CSM	BCI, STI, CSM	BCI, STI, CSM, RR	BCI, STI
Care				VCT, CS, SR
Mitigation	RS, PS, CB	RS, PS, CB	RS, PS, CB	RS, PS, CB
Expanded Coverage	9 districts	7 new districts (total 16)	6 new districts (total 22)	10 new districts (total 32)
Implementing Partners	23 partner organizations	30 partner organizations	32 partner organizations	37 partner organizations

RR=Risk Reduction; CS=Care and support; SR=Stigma Reduction; PS=Policy Support; RS=Research and Surveillance; CB=Capacity Building

FHI'S EXPANDING RESPONSE, 1994–2004



Cumulative Results

Creating Behavior Change, Containing the Spread of HIV and Providing Services to Increasing Numbers of People in Need

Increased Reach: Informing More People through BCI Over Time

In the early years of HIV prevention, FHI defined repeated educational contacts as one of its main indicators. As programs reached FSWs and their clients, this indicator helped to measure quality and quantity of interactions with outreach staff.

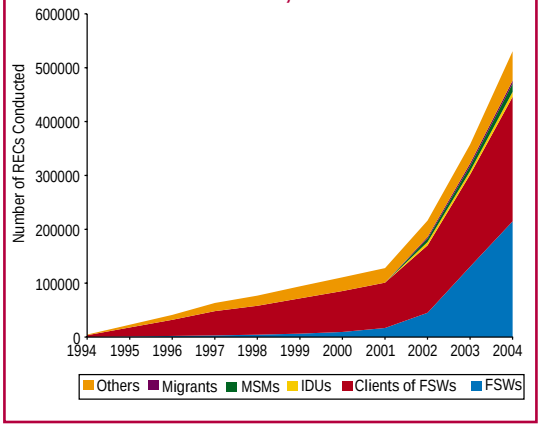
In FHI's first full year of BCI prevention programming in nine districts, over 18,000 RECs were conducted among FSWs, clients of FSWs and secondary groups (other). As FHI expanded its geographic area adding more implementing partners, the larger outreach teams increased the total educational contacts conducted.

By 2004, this annual number had risen almost tenfold, covering six different groups across 29 districts. FSW RECs were 49% of this year's total, while target groups with active programming in small geographic areas were a smaller percentage of the annual total. For example, MSM RECs collected only in Kathmandu Valley account for just over 3%.

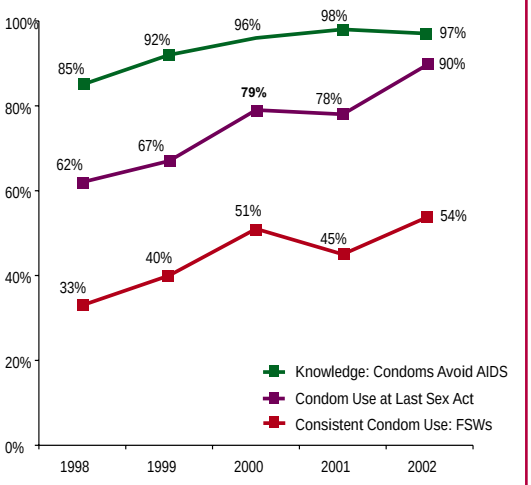
Over the decade of HIV prevention, FHI conducted a total of 530,000 repeated contacts among individuals from target groups. Because of program longevity and expanded coverage, RECs among FSWs and their clients make up 84% of FHI's cumulative total for the decade.

FHI added IDUs, MSM and migrants in the past three years. Almost 30,000 RECs have been conducted among these newer groups in the seven districts where programming is active.

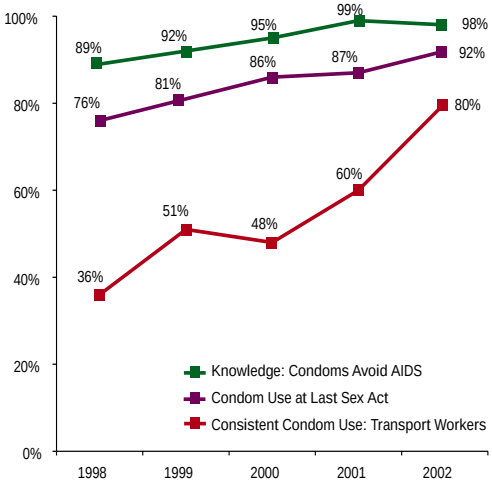
FHI SUPPORT FOR BEHAVIOR CHANGE: REPEATED EDUCATIONAL CONTACTS, CUMULATIVE, 1994-2004



INCREASES IN KNOWLEDGE AND SAFER SEX BEHAVIORS AMONG FSWS



INCREASES IN KNOWLEDGE AND SAFER SEX BEHAVIORS AMONG TRANSPORT WORKERS



Knowing More and Doing More to Protect Themselves: Increased levels of HIV/AIDS knowledge and in behaviors

By 2002, awareness of the importance of using condoms increased to 97.9% among FSWs, 98.7% among transport workers, and 95.5% among male laborers. Research showed that the ratios of those using condoms at their last sexual act increased to 90.3% among FSWs, 91.6% among transport workers and 61.2% among male laborers.

The percentage of FSWs consistently using condoms with their clients increased to 54.3% and the percentage of transport workers consistently using condoms reached 80%.[11]

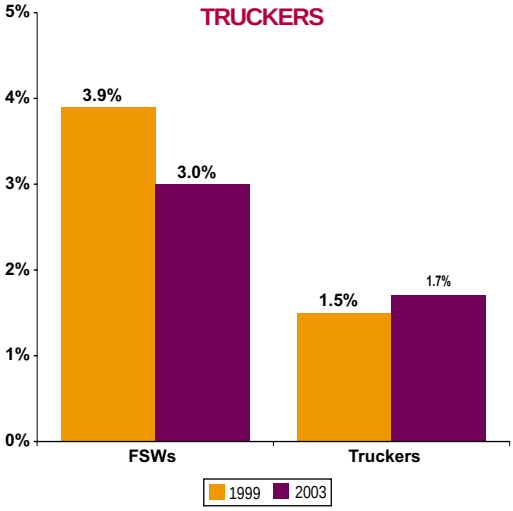
No Increase in HIV Prevalence in FHI Program Area

FHI conducted its first HIV prevalence study in 1999, sampled from its program area of 16 districts along the highways. Both FSWs and their main client group—truckers—participated. This was the first large-scale study of these most at risk groups.

The results of the 1999 study were not alarming–with HIV in both groups under 5%. Considering behaviors and HIV prevalence trends in Kathmandu, continued and expanded HIV prevention activities were needed to be sustained to contain the epidemic in this area.

In 2003, FHI repeated the same study, and the news was very good. HIV has been contained, and no increase in HIV prevalence was found in either group.

NO INCREASE IN HIV PREVALENCE AMONG FSWS OR THEIR MAIN CLIENT GROUP, TRUCKERS

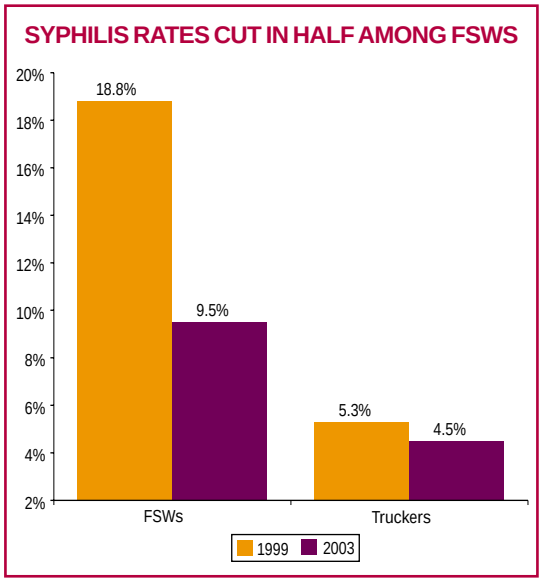


[11] *Behavioral Surveillance Study in the Highway Route of Nepal: Round I-V*, New Era/FHI, 1999–2003

Syphilis Prevalence Drops After Four Years of Focused STI Programming

In the same HIV prevalence study in 1999, FHI also collected the first data on syphilis prevalence from FSWs and the truckers in its program area. In these 16 districts along the highways, syphilis prevalence was almost 20% among FSWs and over 5% among truckers. Because syphilis increases the risk for HIV, FHI responded by redesigning its STI services to add syphilis screening and treatment.

In 2003, the study was repeated. FHI found syphilis was halved among FSWs and dropped by 20% among truckers. While these decreases can not be directly attributed to FHI, STI services focused on syphilis screening and treatment certainly contributed.

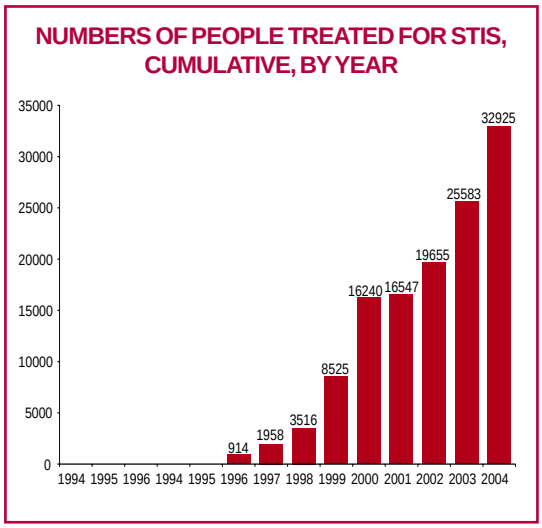


Growing Numbers of People Diagnosed and Treated for STIs

From 1996 when FHI began to offer STI treatment for HIV prevention, these clinical services were designed primarily to reach women, especially FSWs.

For example, in the early years, the family planning clinics offering STI services had over 87% women among their STI patients.

Over the years, FHI has expanded STI services as strategies were refined to better serve those most at risk with a wider range of STI services. In 2004, FHI-supported services diagnosed and treated over 7000 people mainly from most at risk groups such as FSWs.



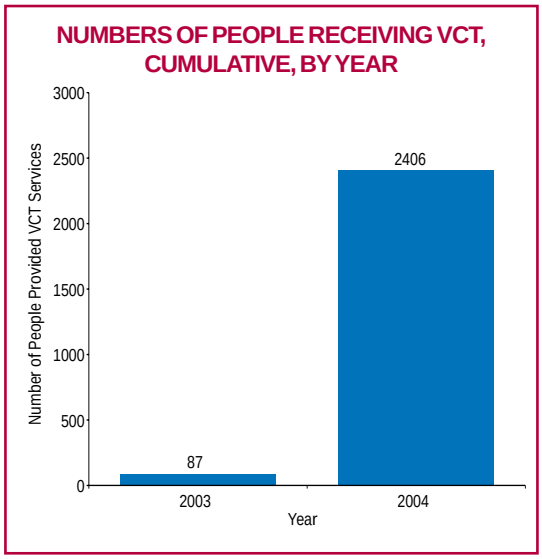
Over the eight years of STI service delivery for HIV prevention, FHI has treated almost 33,000 individuals.

Increased Access and Use of VCT Services

FHI began to support VCT services only in mid-2003 but quickly expanded from one site to 16 in just 18 months. VCT services have been designed to reach those most at risk and the vast majority of the 2,406 people who have received VCT to date are IDUs, FSWs and their partners.

By the end of 2004, clinics that are IDU-friendly find up to 30-40% of the VCT clients are HIV positive. But on average, of the 2,406 that received the full VCT service, 16% tested positive for HIV.

FHI-supported services saw a total of 2,651, but small numbers of VCT clients only completed pre-test counseling or were tested but did not receive their results.



Looking Forward

FHI Future Program Priorities in Nepal

After a decade of work in partnership addressing the challenges of HIV/AIDS in Nepal, FHI looks forward to building on progress to mitigate the impact of the epidemic and provide care for those infected and affected by the disease.

As FHI enters its next decade, support of HMG/N's national HIV/AIDS program remains central to FHI's contributions in HIV/AIDS prevention, care and mitigation. As in the past, all of FHI's work in Nepal is in direct **support of national priorities**–as demonstrated by its three sequential USAID-supported programs and NI. FHI will continue to provide its support and assistance as needed by HMG/N under its current and future national HIV/AIDS strategies and objectives.

Nepal has a diverse range of resources to implement its national HIV/AIDS activities. Over the past 10 years, FHI's support for training, research and implementation has contributed to the **growing pool of Nepali technical and programmatic expertise** throughout the country including:

- Teams of motivated PEs and OREs;
- Clinicians and lab staff appropriately managing STIs;
- Experienced VCT counselors;
- Dozens of skilled field researchers;
- Enthusiastic doctors and nurses treating opportunistic infections (OIs) and providing HIV/AIDS clinical care;
- Blossoming groups and networks of PLHA; and
- Competent , dedicated staff in FHI partner organizations who know how to work in their communities to best help those most at risk.

Nepal has the human resources for HIV/AIDS programming, and as needed FHI offers additional technical resources to complement ongoing or develop new initiatives. One of FHI's unique strengths is its ability to offer **technical assistance** on a wide range of issues, such as treatment, epidemiological surveillance, STI diagnosis and treatment, and VCT.

As more funds become available to address the growing needs for prevention and care, FHI will work to ensure its activities are complementary and not duplicative of other programs. One of the most effective ways to **maximize resources and create synergies** between programs is through partnerships and collaboration. Over the past decade FHI has worked directly and in coordination with numerous organizations, agencies, networks and companies to share information, ideas and resources. **Partnerships** will continue to be central to FHI's work.

Given Nepal's concentrated epidemic, prevention is essential. While effective prevention programs can limit the epidemic's impact, the care and support needs will increase as those already infected become ill. Prevention needs to be **focused among most at risk groups** and be effective and cost-efficient.

Prevention however alone is not enough. Services and systems need to be strengthened to better meet the **care, support and treatment** needs of PLHA. In building and strengthening a continuum of prevention to care services, FHI will work with others to offer a range of services that can be strengthened and expanded over time to more fully meet the needs of PLHA, their families and communities.

One of those services is treatment, which is clearly a pressing priority for Nepal, FHI will work collaboratively with HMG/N, donors, NGOs, PLHA groups, health care providers and HIV/AIDS activists to ensure treatment is available, appropriate and accessible. Treatment needs to be according to international standards, but practical and possible given available resources and the context of Nepal.

As in the past, FHI will its emphasize **evidence-based programming**—especially its support for national surveillance research, systems and plans. FHI will continue to support NCASC to gather needed epidemiological information so the national program can best respond to the changing epidemic.

FHI continues its commitment to **community-based and participatory** programming. In addition to embracing greater involvement of people living with HIV/AIDS (GIPA) principles, involvement of beneficiaries in community assessments, research, implementation and monitoring always has produced better quality programs. Presently, listening and responding to local realities is critical to continuing work without increasing risk. The current political instability increases the challenge of accessibility to those in need of HIV/AIDS prevention and care services, but reaching highly mobile and vulnerable groups has been the nature of FHI's work for many

years. Challenges of politics, economics, gender inequality, cultural constraints and systems capacities will likely be issues of the future and continue to require innovative ways to minimize their impact on providing the highest quality HIV/AIDS services possible.

Together, preventing a generalized HIV/AIDS epidemic in Nepal is achievable if resources are available and partnerships continue to be strengthened. In 2002, UNAIDS stated that in the absence of effective public health interventions, AIDS would be the leading cause of death among adults in Nepal by 2010. FHI is optimistic that its contribution to the national HIV/AIDS program can help avert this crisis. For those already affected, FHI will support national systems to care, support and treat the estimated 60,000 PLHA or more who will access hospital services from the remote hills of Doti to the burgeoning capital of Kathmandu. This is the decade where the HIV/AIDS epidemic can be halted, and FHI looks forward to being part of the comprehensive national response.

Annex

Donors, Implementing Agencies and Collaborating Organizations

Donors

These organizations have helped FHI/Nepal fight HIV/AIDS through their generous financial, knowledge, and partnership support:

- USAID
- DFID
- UNAIDS
- AusAID
- UNICEF
- UNDP
- UNFPA

FHI Implementing Agencies and their partner NGOs

Over the past decade, FHI has financially supported a wide variety of different organizations and agencies to implement HIV/AIDS prevention, care and mitigation activities:

- Adventist Development and Relief Agency (ADRA)
- Auxiliary Nurse Midwife and Community Medical Assistant Program, Kaligandaki Hospital
- Ashraya/Ashmita
- Association for Helping the Helpless
- Association of Medical Doctors in Asia (AMDA)
- Bhaktapur Metropolitan City (BMC)
- Blue Diamond Society (BDS)
- Bhoruka Public Welfare Trust
- B. P. Koirala Institute for Health Science (BPKHIS)
- CARE/Nepal
- Center for Research on Environment, Health and Population Activities (CREHPA)
- Community Action Center (CAC)
- Center for Harm Reduction McFarlane Burnett Institute, (CHR/MBI)
- Community Welfare Center (CWC)
- Equal Access, Nepal
- Family Planning Association of Nepal (FPAN)
- The Futures Group International
- General Welfare Pratisthan (GWP)
- G.P. Rajbahak & Co.
- HELP Group for Creative Community Development (HELP)
- Himalayan International Marketing Associates Ltd. (HIMAL)
- Himalayan Social Welfare Organization (HSWO)
- HIV/AIDS IEC NGO Coordination Committee

- Howard Delafield International (HDI)
- Info-AIDS
- Institute for Community Health (ICH)
- International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B)
- International Nepal Fellowship (INF)
- Jamkabhet Library
- Johns Hopkins University Center for Communication Programs (JHU/CCP)
- Kathmandu Metropolitan City (KMC)
- Knights Chess Club (KCC)
- Kirat Yakthung Chumlung-Punarjiwan Kendra (KYC)
- Lalitpur Sub Metropolitan City (LSMC)
- Lifesaving and Lifegiving Society (LALS)
- Management Sciences for Health (MSH)
- Management Support Service Private Limited (MASS)
- Manushi for Sustainable Development
- Multi Purpose Development Science Institute
- Narayanghat Girls Drama Club
- National Association of the Deaf and Hard of Hearing (NADH)
- National Association of PLHA in Nepal (NAP+N)
- National Center for AIDS and STD Control (NCASC)
- Naulo Ghumti
- Nepal Chemists and Druggists Association (NCDA)
- Nepal CRS Company (CRS)
- Nepal Fertility Care Center (NFCC)
- Nepal Jaycees
- Nepal Medical Association (NMA)
- National Network Against Girl Trafficking (NNAGT)
- Nepal ORG-MARG Pvt. Ltd. (now AC Nielsen)
- Nepal Red Cross Society (NRCS), Bajhang
- Nepal Red Cross Society (NRCS), Central Office
- Nepal Red Cross Society (NRCS), Doti
- Nepal Red Cross Society (NRCS), Kaski
- Nepal Sports Federation Against Drugs and HIV/AIDS (NESFADA)
- Nepal STD and AIDS Research Center (NSARC)
- Nepali Technical Assistance Group (NTAG)
- New ERA
- Oxygen Research and Development Forum (ORDF)
- Prerana
- Program for Applied Technology in Health (PATH)
- Population Services International (PSI)
- Punarjivan Sarokar Kendra (PSK)
- Rural Environment and Development Association
- Sahara Paramarsha Kendra (SPK)
- Samijik Bikas Samuha
- Save the Children/US
- Save the Environment
- Secretariat of the Second National Conference on AIDS
- Siddhi Memorial Hospital
- Social Awareness Development Group (SAD Group)
- Social Marketing and Distribution (SMD)
- Society for Education and Developmental Activities (SEDA)
- Secretariat of the South Asian Regional Conference of Dermatology (SARCD)
- Sri Ram Yuwa Committee
- STD/AIDS Counseling and Training Services (SACTS)
- Stimulus Advertizers
- Student Awareness Forum (BIJAM)
- TARANGA Sanskritic Samuha
- TB Net
- Thompson Nepal
- Trinetra Community Development Foundation Nepal
- United Mission to Nepal (UMN)
- United States Peace Corps
- University of North Carolina (UNC)
- Valley Research Group (VaRG)
- Voluntary Services Overseas Nepal (VSO/N)
- Women Acting Together for Change (WATCH)
- Women Skill Creation Centre
- Youth Power Nepal
- Youth Vision

Collaborating Organizations

Other important partnerships and collaborative relationships have been essential to ensuring quality HIV/AIDS programming that supports HMG/N objectives without duplicating efforts. Some of the organizations FHI has worked collaboratively with over the past 10 years include:

- American Foundation for AIDS Research (AmFAR)
- Center for Development and Population Activities (CEDPA)
- European Economic Community (EEC)
- Gesellschaft fuer technische Zusammenarbeit (GTZ)
- International Labor Organization (ILO)
- Journalists Against AIDS in Nepal (JAAN)
- Marie Stopes International
- Ministry of Communication and Information
- Ministry of Health
- Ministry of Home
- Ministry of Social Welfare
- Ministry of Population and the Environment
- National Center for AIDS and STD Control (NCASC)
- Narayani Transport Enterpreneurs Association
- National Public Health Laboratory (NPHL)
- National Tuberculosis Center
- Naz Foundation International
- Nepalese Society of Obstetrics and Gynecology (NESOG)
- Netherlands Development Organization (SNV)
- Patan Hospital
- Program for Applied Technology in Health (PATH)
- Swiss Development Corporation (SDC)
- Transport Corporation of India (TCI)
- The Asia Foundation (TAF)
- Tribhuvan University Teaching Hospital (TUTH)
- United Nations Children's Fund (UNICEF)
- United Nations Population Fund (UNFPA)
- University of Heidelberg (UOH)
- United States Embassy
- World Bank
- World Health Organization (WHO)

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anitretroviral therapy
BCI	Behavior Change Interventions
BSS	Behavioral Surveillance Survey
CIP	Community-based Information Point
CSM	Condom Social Marketing
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DIC	Drop-In Center
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government of Nepal
HSS	HIV Sentinel Surveillance
IA	Implementing Agency
IBBS	Integrated Bio-behavioral Survey
IDU	Injecting Drug User
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
NAP+N	National Association of PLHA in Nepal
NCASC	National Center for AIDS and STD Control
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
OI	Opportunistic Infection
ORE	Outreach Educator
PE	Peer Educator
PHC	Primary Health Care
PHSC	Protection of Human Subjects Committee
PLHA	People Living with/Affected by HIV/AIDS
RNA	Royal Nepalese Army
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Family Health International
HIV/AIDS Prevention, Control and Care Program
Nepal Country Office
PO Box 8803, Gairidhara, Kathmandu, Nepal
Tel: 977-1-4427540, 4437173
Fax: 977-1-4414063
E-mail: fhinepal@fhi.org.np
Web: www.fhi.org